

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

10716

1. PLACE OF DEATH:

County... Queen AnneCity or town... Queenstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Queen AnneCity or town... Queenstown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cassie Green Boulden

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 10 - 1870

8. AGE: Years Months Days If less than one day

77 11 21 hrs. min.9. Birthplace Queen Anne's Bay, Md
(Town, county, and state)10. Usual occupation Retired11. Industry or business House work12. Name Chas Green13. Birthplace Queen Anne's Bay, Md14. Maiden name Mary Hutton15. Birthplace Queen Anne's Bay, Md16. Informant Chas GreenAddress Queenstown Md17. Burial Date thereof Nov 2 - 48
(Burial, cremation, or removal, Where) (month) (day) (year)Cemetery or crematory St Peter's cemeteryLocation Queenstown Md19. Funeral director John D. SullivanAddress Easton Md19. Nov. 2 - 48 Helen M. Aedridge
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 19 48 at 1:40 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 19 48 to Oct 30 19 48and that I last saw him alive on Oct 30 19 48

Immediate cause of death

Cerebral Hemorrhage, I.
Arteriosclerotic Cardio-
vascular disease

DURATION

5 days10 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William G. Lowe MD

M. D. or other

Address Queenstown, Md Date signed 11-1-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

10717

153

1. PLACE OF DEATH:

County Queen Anne's
 City or town rust Centerville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louis S. Conyer

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 27-1945

8. (c) If alive, give age..... Years

8. AGE:

Years

Months

Days

If less than one day

300

hrs.

min.

9. Birthplace

Baltimore Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Alvin Preston Conyer

13. Birthplace

Grassville Maryland

14. Maiden name

Mary R. Little

15. Birthplace

Grassville Maryland

16. Informant

Alvin Preston Conyer

Address

Centerville Maryland

17.

Buried
(Burial, cremation, or removal. Which?)

Date thereof

Oct 28-48
(month) (day) (year)

Cemetery or crematory

Grassville

Location

Grassville Maryland

18. Funeral director

T. B. Bros

Address

Centerville Maryland

19.

10-28-48
(Date rec'd by registrar)Elie Armistead
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town rust Centerville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1948 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 9 1946 to Oct. 27 1948and that I last saw him alive on Sept. 28 1948Immediate cause of death Kachexia

DURATION

3 years

Due to

Physical & mental retardation

Due to

Other conditions

Helicobacter

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Elie Armistead M.D.
M. D. or otherAddress Chose Anne Md Date signed 10/29/48

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10718

Reg. Dist. No. 251

1. PLACE OF DEATH:

County 928
 City or town Berkeley Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred:
NO
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Queen Anne
 City or town Berkeley
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Hensley Harrison
 4. Sex M 5. Color or race Black 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife

Martha Harrison

7. Birth date of deceased (mo., day, yr.) (unknown) 1881 6.(c) If alive, give age 60(?) years

8. AGE: Years 67(0) Months — Days — If less than one day — hrs. — min.

9. Birthplace 928
 (Town, county, and state)

10. Usual occupation born Navy

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Martha Harrison

Address Berkeley Ind.

17. Burial Date thereof Oct 16-1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Berkeley Ind.

Location Berkeley Ind.

18. Funeral director Edgar A. Lane

Address Church Hill Ind.

19. Oct. 14 19 48 Edgar A. Lane
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 19 48 at 9:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13 19 48 to Oct 13 19 48
 and that I last saw him alive on Oct 13 19 48

Immediate cause of death Acute Cardiac Disturbance DURATION

Due to Stroke from Artery Stone

Due to Stroke Artery Thrombosis

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE C. W. White M. D. or other

Address Berkeley Ind. Date signed 10/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1948
BUREAU A. S.

1948

67

1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Burrsville</u>		CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Burrsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>A.</u> (Last) <u>Nelson</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>19</u> (Year) <u>1948</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 10 - 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days If under 24 hrs. Min.
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Garrison Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Pierce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Anna L. Pierce</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Mitral Regurgitation</u>			
Antecedent cause(s) (b) <u>Nephritis</u>			
(c) <u>None</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>Home</u>	
CITY OR TOWN <u>Burrsville</u> COUNTY <u>Queen Anne</u> STATE <u>Ind.</u>			
TIME (Month) (Day) (Year) (Hour) <u>None</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>Sept 2nd 1948</u> to <u>Oct 19 1948</u> , that I last saw the deceased alive on <u>Oct 18</u> , 1948, and that death occurred at <u>11 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Dr. Harrison S. Bell</u>		DATE SIGNED <u>Feb 4 1949</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct 22 - 1948</u>	
NAME OF CEMETERY OR CREMATORY <u>Burrsville</u>		LOCATION (City, town, or county) <u>Burrsville Ind.</u>	
DATE REC'D BY LOCAL REG. <u>2-7-49</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> ADDRESS <u>Church Hill Ind.</u>	

COPY

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RECEIVED
FEB 14 1949
BUREAU T. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

10719

1. PLACE OF DEATH:

County Queen Anne's
 City or town Prine Centerville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's
 City or town Prine Centerville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Linda Marlene Richardson

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 21, 1948

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

824 hrs.0 min.

9. Birthplace

Prine Queen Anne's Co Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct 26-48
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Oct 25-48Elin ArmstrongPrine Centerville, Md
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 241948, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 211948

to

10/241948and that I last saw him alive on Oct. 23

Immediate cause of death

Spinal Cord

Due to

Due to

Other conditions

malformation of hip + pelvis
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. McPherson

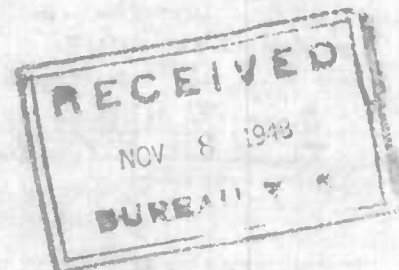
M. D. or other

Address

Prine Centerville, Md

Date signed

10/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10720

93d

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen Anne's
 City or town near Englishside
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 1 week
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Queenstown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Mollie Frances Poe

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

September 28 - 1885

8. AGE:

63019hrs.min.

9. Birthplace

Queenstown 20 Co. Maryland
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

MOTHER FATHER

12. Name

James H. Poe

13. Birthplace

Delaware

14. Maiden name

Rafanna Morris

15. Birthplace

Delaware

16. Informant

Mrs Annie E. Anthony

Address

Queenstown Maryland

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

Oct 20 - 48
(month) (day) (year)

Cemetery or crematory

Centerville

Location

Centerville Maryland

18. Funeral director

Boyer Boyer

Address

Centerville Maryland

19. Oct 18

(Date rec'd by registrar)

19 48

Edgar R. Lane
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 1719 48 at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1319 48 to Oct 1719 48

and that I last saw him alive on

Oct 1319 48

Immediate cause of death

Coronary Atherosclerosis

DURATION

Due to

Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. H. Upstake

M. D. or other

Address

Centerville Md

Date signed

10/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10721

Reg. Dist. No. 251

1. PLACE OF DEATH:

County..... Green Anne
 City or town..... Rural Church Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Green Anne
 City or town..... Rural Church Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) if veteran, name war.....

3. (a) FULL NAME

Ruby Ruth Stubbs

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... Thomas Stubbs 6. (c) If alive, give age..... 50 years
 7. Birth date of deceased (mo., day, yr.)..... Nov. 21 - 1895
 8. AGE: Years..... 52 Months..... 10 Days..... 17 If less than one day..... hrs. min.
 9. Birthplace..... Millington - Kent. Ind.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....
 12. Name..... V. Shell
 13. Birthplace..... ga. Co. Ind.
 14. Maiden name..... Op-habe Hazel
 15. Birthplace..... Ind.

MOTHER FATHER

16. Informant..... I hos. Stubbs
 Address..... Church Hill Ind
 17. Burial..... Burial Date thereof..... Oct. 12 - 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Church Hill
 Location..... Church Hill Ind
 18. Funeral director..... Edgar L. Kane
 Address..... Church Hill Ind.
 19. Oct. 9 1948 Edgar L. Kane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 8 1948 at 9 15 P. M.
 21. CERTIFY that death occurred on the date above stated; that I attended the deceased from September 1948 to Oct 8 1948
 and that I last saw the deceased alive on Oct 8 1948
 Immediate cause of death..... Stomach cancer DURATION..... 1 mo
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Cancer of stomach
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... Edgar L. Kane M. D. or other
 Address..... Church Hill Date signed..... Oct 9



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: *Lucan Home*
 County.....
 City or town..... *Chesapeake Bay.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *4 yrs*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... *Virginia* County..... *Norfolk*
 City or town..... *Norfolk*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *924 Western Road*
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... *World War #1*

3.(a) FULL NAME *Geo. L. Williamson*

3.(b) Social Security Number
232-30-0947

4. Sex *male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *married*
 6.(b) Name of husband or wife..... *Ester Spain*
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) *Oct 4 - 1892*
 8. AGE: Years *56* Months *0* Days *15* hrs. min.

9. Birthplace..... *Seam Point, North Carolina*
 (Town, county, and state)

10. Usual occupation..... *Seaman*

11. Industry or business..... *Ester Transportation Co*

12. Name..... *John Williamson*

13. Birthplace..... *North Carolina*

14. Maiden name..... *Sallie Rose*

15. Birthplace..... *North Carolina*

16. Informant..... *Mr. Ester Williamson*

Address..... *924 Western Rd Norfolk, Va.*

17. Burial..... *Reserve*

Date thereof..... *Nov 3 - 1948*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Reserve*

Location..... *Norfolk Virginia*

18. Funeral director..... *1 Barton Bros*

Address..... *Centerville, Maryland*

19. Nov. 1 - 1948 *Elin Amateasing*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *? about Oct 19* 19 *48* at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... *live* on..... 19.....

Immediate cause of death..... *This man was found dead on shore on Kent Island - He had a*

Due to..... *Life forever stopped on*

Death was due to..... *drowning*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... *Accident* Date of.....

Where did injury occur?..... (City or town) (County) (State)

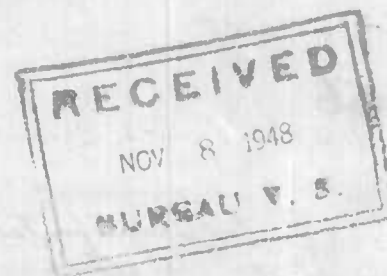
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *W. Henry Fisher*

Address..... *Centerville Md*

Date signed..... *10/31-48*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10723

488

254

Reg. Diat. No.

1. PLACE OF DEATH:

County Queen Anne's
City or town Rural Queenstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? see her life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Queen Anne's
City or town Rural Queenstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Susie E. Wrightson

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband Surge B. Wrightson
7. Birth date of deceased (mo., day, yr.) Jan 12 - 1873 B. (c) If alive, give age years
8. AGE: Years 75 Months 9 Days 1 If less than one day hrs. min.

9. Birthplace Queen Anne's Co. Maryland
(Town, county, and state)
10. Usual occupation Housewife

11. Industry or business

12. Name William J. Dadds
13. Birthplace Queen Anne's Co. Maryland
14. Maiden name Elizabeth Allen
15. Birthplace Talbot Co. Maryland

16. Informant Willard H. Wrightson
Address Queenstown Maryland

17. Burial Date thereof Oct 15 - 1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chestertown
Location Centerville Maryland

18. Funeral director Patton Bros
Address Centerville, Maryland

19. Oct. 15 19 48 H. M. Aldridge
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 19 48 at 1300 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 19 48 to Oct 13 19 48
and that I last saw her alive on Oct 13 19 48

Immediate cause of death Carcinoma of stomach
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Charles Triple
Stevensville M. D. or other
Address Stevensville Date signed 10/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 21 1948
BUREAU V. S.